Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS HEALTH HEB
3255 W PIONEER PKWY
PANTEGO TX 76013-4620

Respondent Name
NEW HAMPSHIRE INSURANCE COMPANY

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-12-2517-01

MFDR Date Received
April 3, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to the contract with First Health, this provider is to be paid at 65% of billed charges. I have also included the pertaining page of the contract the applies to this. Please submit this to the carrier for the correct allowable as all they continue to state is that it is paid by the contract and it is not."

Amount in Dispute: $10,583.48

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Requestor billed $23,788.99 and maintains that the carrier did not reimburse per a contact with First Health Network. I have asked our medical billing division to determine if our system software was updated at the time this bill was submitted as that may be the reason for the discrepancy. I will advise the requestor and the DWC when I determine why the payment differs from the contracted amount shown by the requestor and we will issue any payments that are due per the contract."

Response Submitted by: Chartis, 4100 Alpha Road, Suite 700, Dallas, Texas 75244

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
May 4, 2011 to May 6, 2011	Outpatient Hospital Services	$10,583.48	$3,099.99

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the

reimbursement guidelines for professional medical services.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - W1 – Workers Compensation State Fee Schedule Adjustment.
   - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
   - 94 – Processed in Excess of charges.
   - 96 – Non-covered charge(s).
   - 1 – This is a bundled or non covered procedure based on Medicare guidelines; no separate payment allowed. (B291)
   - 2 – Recommendation of payment has been based on this procedure code, 36415, which best describes services rendered. (Z652)
   - 3 – This contracted provider or hospital has agreed to reduce this charge below fee schedule or usual and customary charges for your business. (P303)
   - 4 – This bill was reviewed in accordance with a Coventry-First Health owned contract. For questions regarding this analysis, please call 1-800-937-6824. (Z547)
   - 5 – Recommendation of payment has been based on this procedure code, 80053, which best describes services rendered. (Z652)
   - 6 – The charge for this procedure exceeds the fee schedule allowance. (Z710)
   - 7 – Recommendation of payment has been based on this procedure code, 93005, which best describes services rendered. (Z652)
   - 8 – This is a packaged service based on Medicare guidelines as defined in the CMS-Publication 60A, which states: Packaged Revenue Codes The following revenue codes when billed under OPPS without HCPCS codes are packaged services for which no separate payment is made. However, the cost of these services is included in the transitional outpatient payment (TOP) and outlier calculations. The revenue codes for packaged services are: 0250, 0251, 0252, 0254, 0255, 0257, 0258, 0259, 0260, 0262, 0263, 0264, 0269, 0270, 0271, 0272, 0275, 0276, 0278, 0279, 0280, 0289, 0370, 0371, 0372, 0379, 0390, 0399, 0560, 0569, 0621, 0622, 0624, 0630, 0631, 0632, 0633, 0637, 0700, 0709, 0710, 0719, 0720, 0721, 0762, 0810, 0819 and 0942. Any other revenue codes that are billable on a hospital outpatient claim must contain a HCPCs code in order to assure payment under OPPS. Return to provider (RTP), claims which contain revenue codes that require a HCPCS code when no HCPCS code is shown on the line. No separate payment allowed. (XE27)
   - 9 – Recommendation of payment has been based on this procedure code, 29826, which best describes services rendered. (Z652)
   - A – The recommended allowance on this line is based on TX fee schedule reimbursement guidelines which allows greater than the providers billed charges. (ZOBC)
   - B – Recommendation of payment has been based on this procedure code, 82962, which best describes services rendered. (Z652)
   - C – Recommendation of payment has been based on this procedure code, 88304, which best describes services rendered. (Z652)
   - D – Recommendation of payment has been based on this procedure code, 88311, which best describes services rendered. (Z652)
   - E – Procedure code not separately payable under Medicare and or Fee Schedule guidelines. (U634)
   - F – Recommendation of payment has been based on this procedure code, C1713, which best describes services rendered. (Z652)
   - G – Recommendation of payment has been based on this procedure code, J0171, which best describes services rendered. (Z652)
   - H – Recommendation of payment has been based on this procedure code, J0330, which best describes services rendered. (Z652)
   - I – Recommendation of payment has been based on this procedure code, J1885, which best describes services rendered. (Z652)
   - J – Recommendation of payment has been based on this procedure code, J2250, which best describes services rendered. (Z652)
   - K – Recommendation of payment has been based on this procedure code, J2405, which best describes services rendered. (Z652)
   - L – Recommendation of payment has been based on this procedure code, J3010, which best describes services rendered. (Z652)
   - M – Recommendation of payment has been based on this procedure code, J7120, which best describes services rendered. (Z652)

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced/denied payment for disputed services with reason codes 3 – "This contracted provider or hospital has agreed to reduce this charge below fee schedule or usual and customary charges for your business. (P303)"; 4 – "This bill was reviewed in accordance with a Coventry-First Health owned contract. For questions regarding this analysis, please call 1-800-937-6824. (Z547)"; and 45 – "Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement." Per Labor Code §413.011(d-6) the provisions that authorized insurance carriers to contract with health care providers for fees that are different from those specified by the Division's fee guidelines expired on January 1, 2011. No information was found to support that the services in dispute are subject to a contractual agreement related to a workers' compensation health care network that had been certified under Insurance Code Chapter 1305. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

   - Procedure code C1713 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code 36415 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.00. 125% of this amount is $3.75. The recommended payment is $3.75.
   - Procedure code 80053 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $14.87. 125% of this amount is $18.59. The recommended payment is $18.59.
   - Procedure code 82962 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.29. 125% of this amount is $4.11. The recommended payment is $4.11.
   - Procedure code 88304 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. This service is classified under APC 0343, which, per OPPS Addendum A, has a payment rate of $36.48. This amount multiplied by 60% yields an unadjusted labor-related amount of $21.89. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of $20.93. The non-labor related portion is 40% of the APC rate or $14.59. The sum of the labor and non-labor related amounts is $35.52. The cost of this service does not exceed the annual fixed-

dollar threshold of $2,025. The outlier payment amount is $0. The total APC payment for this service is $35.52. This amount multiplied by 200% yields a MAR of $71.04.

- Procedure code 88311 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. This service is classified under APC 0342, which, per OPPS Addendum A, has a payment rate of $11.04. This amount multiplied by 60% yields an unadjusted labor-related amount of $6.62. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of $6.33. The non-labor related portion is 40% of the APC rate or $4.42. The sum of the labor and non-labor related amounts is $10.75. The cost of this service does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total APC payment for this service is $10.75. This amount multiplied by 200% yields a MAR of $21.50.
- Procedure code 23410 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. This service is classified under APC 0051, which, per OPPS Addendum A, has a payment rate of $3,259.30. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,955.58. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of $1,869.73. The non-labor related portion is 40% of the APC rate or $1,303.72. The sum of the labor and non-labor related amounts is $3,173.45. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than $1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than $1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of $3,173.45 divided by the sum of all S and T APC payments of $4,204.82 gives an APC payment ratio for this line of 0.754717, multiplied by the sum of all S and T line charges of $6,702.75, yields a new charge amount of $5,058.68 for the purpose of outlier calculation. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $2,025, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.239. This ratio multiplied by the billed charge of $5,058.68 yields a cost of $1,209.02. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for this service of $3,173.45 divided by the sum of all APC payments is 74.65%. The sum of all packaged costs is $3,892.67. The allocated portion of packaged costs is $2,905.89. This amount added to the service cost yields a total cost of $4,114.91. The cost of this service exceeds the annual fixed-dollar threshold of $2,025. The amount by which the cost exceeds 1.75 times the OPPS payment is $0.00. The total APC payment for this service is $3,173.45. This amount multiplied by 200% yields a MAR of $6,346.90.
- Procedure code 29824 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. This service is classified under APC 0041, which, per OPPS Addendum A, has a payment rate of $2,064.02. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,238.41. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of $1,184.04. The non-labor related portion is 40% of the APC rate or $825.61. The sum of the labor and non-labor related amounts is $2,009.65. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than $1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than $1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of $1,004.83 divided by the sum of all S and T APC payments of $4,204.82 gives an APC payment ratio for this line of 0.238971, multiplied by the sum of all S and T line charges of $6,702.75, yields a new charge amount of $1,601.76 for the purpose of outlier calculation. The cost of this service does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total APC payment for this service, including multiple-procedure discount, is $1,004.83. This amount multiplied by 200% yields a MAR of $2,009.66.
- Procedure code 29826 is unbundled. This procedure is a component service of procedure code 23410 performed on the same date. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.

- Procedure code J0171 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J0330 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J1885 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2250 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2405 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J3010 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J7120 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 93005 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. This service is classified under APC 0099, which, per OPPS Addendum A, has a payment rate of $27.26. This amount multiplied by 60% yields an unadjusted labor-related amount of $16.36. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of $15.64. The non-labor related portion is 40% of the APC rate or $10.90. The sum of the labor and non-labor related amounts is $26.54. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than $1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than $1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of $26.54 divided by the sum of all S and T APC payments of $4,204.82 gives an APC payment ratio for this line of 0.006312, multiplied by the sum of all S and T line charges of $6,702.75, yields a new charge amount of $42.31 for the purpose of outlier calculation. The cost of this service does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total APC payment for this service is $26.54. This amount multiplied by 200% yields a MAR of $53.08.

4. The total allowable reimbursement for the services in dispute is $8,528.63. This amount less the amount previously paid by the insurance carrier of $5,428.64 leaves an amount due to the requestor of $3,099.99. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $3,099.99.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $3,099.99, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	November 15, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.